SENIOR & LONG TERM CARE DIVISION
COMMUNITY SERVICES BUREAU

HOME AND COMMUNITY BASED WAIVER Policy Manual	Section: SERVICES
	Subject: Post-acute Rehabilitation Services

References: ***ARM: 37.40.1446***

DEFINITION

Post-acute Rehabilitation is a residential and non-residential program for persons with traumatic brain injury, or other severe disability that would benefit from these services. It is intended to maximize functional independence through therapeutic intervention that provides intensive therapies 3 to 5 days a week. Members are taught strategies to overcome barriers created by their disability, learn compensatory techniques for memory loss and behavior problems and re-learn day-to-day living skills. The goal of this program is to facilitate integration into the community in addition to reducing the level of disability for the member. Treatment may include initial assessment, evaluation and follow up activities including short term tune up sessions.

SERVICE REQUIREMENT

Post-acute rehabilitation is provided by an agency under the direction of an interdisciplinary team consisting of a board certified physiatrist, a licensed neuropsychologist, or a licensed psychologist, therapist and other appropriate support staff. A provider of this service must be accredited by CARF as a Community Re-Entry Program for Persons with a traumatic brain injury or receive such accreditation within two years of commencement of this service under the HCBS program. Outcome information is to be supplied from provider to program manager.

SERVICE LIMITATIONS

This service is limited to Care category 3 (CC3) members who have a traumatic brain injury or other severe disability that requires intensive services. Current providers are limited to Bridges for both residential and non-residential and Headways for only non-residential.

Therapies provided under this service are not duplicative of those available under State Plan nor will they be provided simultaneously with occupational, speech or physical therapies provided under the waiver.

PAYMENT

Money for Bridges/Headways, **including case management fees** do not come of case management team (CMTs) budgets and a prior authorization to CSB is not required. Designated teams in Missoula and Billings will report all Bridges/Headways expenditures on their utilization reports. The CMTs only report case management fees under the appropriate slot category.

BRIDGES HEADWAYS REFERRAL PROCESS

New Referrals:

The following steps for new referrals to the Bridges/Headways program, i.e., individuals who are not yet HCBS members:

Local HCBS case management team (CMT) does a home visit to evaluate the need for services. Discharge plan needs to be formulated prior to admission to Bridges/Headways and explain to the member that entry into Bridges/Headways is dependent upon a feasible discharge plan. A discharge plan to HCBS must include the availability of a slot. If the member would need a supported living slot, the CMT would need to complete the appropriate paperwork (amendment or prior authorization) and send to the Regional Program Officer (RPO) for approval.

1. Local HCBS CMY makes a referral for post-acute rehabilitation using the program referral form. See referral forms for Bridges and for Headways immediately following this section.

2. If the individual, Bridges/Headways staff, and CMT agree the program is appropriate, it is decided which CMT will provide case management and an admit date is set. The team that provides case management makes a referral for a level of care screen (depending upon the circumstances, this can be a complete screen or a modified screen) and financial eligibility determination and ensures that all appropriate paperwork associated with enrollment in HCBS is completed, including the PA for Xerox and SLTC 55; unless this was done beforehand.

3. Member is admitted to the Traumatic Brain Injury (TBI) program for a two-week evaluation or amount of time decided by the Bridges/Headways staff and CMTs.

4. After a two-week period, conduct a team meeting with case management team and evaluated if the discharge plan is appropriate.

The CMT and post-acute rehabilitation staff will make a determination about staying longer.

5. HCBS CMT will have formally regularly scheduled meetings with Bridges/Headways program staff, member and others. Informal meetings will be scheduled as necessary. Bridges/Headways staff should initiate this but case manager should monitor. These meetings can be initiated by either Bridges/Headways staff or the CMT.

6. Post-acute rehabilitation will not provide services unless a waiver team is assigned for long term follow along.

Existing HCBS Member Referral:

If the local HCBS CMT remains as the CMT, they can continue to bill the daily rate for CMT while the member is at Bridges/Headways.

1. Send referral form and other pertinent information to Bridges or Headways. If the individual, Bridges/Headways staff and CMT agree that the program is appropriate, make necessary arrangement for admission to the program.

2. Send intake/discharge sheet to MPQH to change service category if appropriate. If member is already in a CC3 slot no change is required. Complete amendment and Xerox Prior authorization for Bridges/Headways.

3. Member is admitted to TBI program for a two-week evaluation or amount of time decided by the Bridges/Headways staff and CMTs.

4. After a two-week period, conduct a team meeting with CMT and evaluate if the discharge plan is appropriate. The CMT and Bridges/Headways will make a determination about staying longer.

5. HCBS CMT will have formal regularly scheduled meetings with Bridges/Headways program staff, member and others. Informal meetings will be scheduled as necessary. Bridges/Headways should initiate this but CMTs should monitor. These meetings can be initiated by either Bridges/Headways or the CMT.

Upon discharge form Bridges/Headways program:

1. If appropriate send discharge sheet to MPQH.

2. Bridges/Headways and local CMT coordinate discharge and transfer of information to permanent team.

3. At discharge from Bridges/Headways program, permanent CMT must have a viable discharge plan and a slot if entering waiver services.

4. CMT send Intake Sheet to MPQH to change care category if necessary.

5. If member is going into supported living slot, CMT confirms admit to CC3 supported living slot and send admit date to the Regional Program Officer (RPO) and the HCBS Program Manager.

6. If necessary, CMT completes an amendment to care plan and cost sheet to reflect change in status. Cost sheet should only be amended if there is change in services or units of service.